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## **Formal services**

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**Social Geographies of Rural Mental Health  
(ESRC Funded Research Project, Award No.R000 23 8453)**

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# Formal Care Services

## Introduction

This findings paper documents what mental health service users in the Highlands think about the formal service provision available to them. Views have been collected across the four case study areas, although those from people in the three rural study areas are privileged. These views are grouped together here in order to provide overall evaluations of the role of key services such as psychiatrist consultation, Community Psychiatric Nursing services (CPNs), General Practitioner support (GPs) and Training and Guidance schemes (TAG units). One area-specific service, the Travelling Day Hospital (TDH) in Easter Ross, is discussed in an appendix. The paper begins with a summary of some of the basic access issues that users<sup>1</sup> perceive to be important when thinking about the use of mental health services in the Highlands. In particular, issues surrounding the uneven geography of service provision are given attention, as well as crucial travel and transport concerns for users living in places distant from centres of population. The paper then outline users' views on the specific services mentioned above, and concludes with general reflections on certain commonly voiced concerns to do with medication use, future service provision and crisis care in rural and remote localities.

## Accessing mental health services

For people with mental health problems in the Highlands, access to mental health care is a big issue, although the issue is configured differently in different places. The issue is first and foremost a profoundly geographical one, given a highly uneven distribution of mental health services and hence a decidedly patchy coverage of provision (see also our findings paper on **Spatial differences**), one result of which is that many users have to travel large distances to reach the sites where services are available. There are a few outreach services such as the CPNs and peripatetic services such as the TDH, it is true, but these services are also plagued by the difficulties of achieving coverage across large areas of dispersed population. We will explore such geographical factors at some length below, but it is important to add that there are also other factors affecting access and pathways to mental health services in the Highlands. These other factors include cultural difficulties in 'asking for help', such as the availability or otherwise of relevant information and the attitudes and referral patterns of GPs. The concerns raised by interviewees apply to both the first accessing of mental health services and the routine access issues experienced thereafter.

### *Pathways into mental health care*

For some people their first access to mental health services occurs because of a crisis situation. A mental health problem may have been ongoing for some time, help may not have been sought or given, and the problem at some point in time has exploded into a mental health crisis. In this instance, first access to care may well be through a traumatic process of police and ambulance involvement, together with drastic medical measures to calm an individual:

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<sup>1</sup> Throughout the document we refer to 'users', denoting users of mental health services.

*It seems to me that if you go wrong mentally up here, you get left until you've gone really wrong, you know, like there's no point in fixing the telly if you can bang it on the top and it starts working again ... . Well, if they can ... 'bang you on the top' and you start sort of like functioning sort of fairly normally, they just leave you alone until you've completely broken down, you know. You've gotta completely do something seriously over the top before they take you seriously around here, because there's so many people saying 'I can't cope, I can't sleep, I'm depressed', then you just hear it so much it doesn't have any impact on them any more. [Ruth, NWS, 11/7/01]*

*I would come down here and in the past I have had literally screaming mad before anyone took any notice of me. The last time I was ill I came down here in the summertime and I was really ill and nobody did anything about it. The CPN came to see me, and then I should have been taken to hospital, I eventually had to. The police came and I went to the Cabin, I was abusive to the doctor, the GP and everybody else, and they had to take me away because I was obviously just out of my tree. It's ridiculous that you have to be that ill. [Julia, SL, 17/9/01]*

In these two quotes, interviewees who live in different parts of the west coast note how access to hospital mental health services came only in times of acute crisis. In the first quote Ruth, a carer, notes that so many people in her area complain of mental health problems and display similar symptoms that appropriate access to hospital care is not forthcoming to those who really need it. Julia notes parallel experiences on Skye whereby hospital admission only occurs when a level of mental distress had reached a danger point. There are several possible reasons for these experiences, but some interviewees point to a general perception that an increasingly constrained hospital service (due to fewer beds) means that patients are now *not* routinely referred for hospital care, when in fact they might need to be: *'I think probably now you need to be more unwell because there are so few hospital beds, you have to be more unwell to get into hospital'* [Michelle, INV, 11/5/01]. The impact of accessing hospital care in crisis is clearly distressing for interviewees, especially for the first time, and also has implications in terms of both community knowledge of an individual's mental health problems and community acceptance post hospital admittance. We deal with crisis situations and services further below.

Although a fair proportion of our interviewees have had some form of crisis management in terms of service access, notably emergency admittance to Craig Dunain or New Craigs in Inverness, many users of mental health services have first accessed care in other ways, mainly though GP referral. Accessing mental health care through GP services is hence the most common pathway to care in the Highlands, but there are many issues bound up in accessing GP care for mental health problems. Some of these are explored below in a specific discussion of GP care, but for now we note that many interviewees tell of initially finding it difficult to access GP services: *'I found it quite difficult talking to him ... because I felt I was keeping the surgery back and I didn't think that was fair'* [Jessica, NWS, 18/7/01]. For some, a reluctance to consult the GP may be linked to how mental health problems are seen in Highland culture, and it is revealing to hear both Connor's [NWS, 16/7/01] claim that *'[a]sking for help can be a sign of weakness'* and Susan's [SL, 20/9/01] claim that *'I was wary of going to the doctor at the start because I thought 'I am not going to be not well''*. A regional trait of resilience, of bearing up in the face of adversity, is perhaps playing

a role here in decisions not to access GP or other services despite feeling mentally unwell. Tellingly, we heard the chastening news that some users may actively *refrain* from trying to access services out of hours because they appreciate just how stretched are the likes of GPs and CPNs trying to deal with ‘clients’ spread across such large areas (see also below):

*If you still have control over what you are doing in general and if you still have some respect for other people, then it does ... you don't call a doctor out if you are not sure ... . [A] couple of occasions I have phoned [the CPN] out of hours and I have been referred to the GP and I think I have stopped at that moment. [Josephine, NWS, 4/7/01]*

In other words, the resilience angle kicks in to make people feel ‘I can cope’, so that they elect *not* to bother service providers. What may also be relevant is a fear of being locally labelled and even stigmatised as ‘mentally ill’:

*That's what people are frightened of, why they are reluctant to seek help because they know that they are going to have a label placed on them for the rest of their lives ... they will be remembered for years by people in the community. [Phillip, SL, 9/8/01]*

These cultural matters are of much wider significance for our whole project, of course, and we explore them further in a section of this paper below. (See also our findings papers on **Highlands, economy, culture and mental health problems** and **Experiencing mental health problems**).

For some people, it is not just cultural and confidentiality reasons that prevent them from getting to the point of going to their GP, it is also due to a lack of information about what can be done to help them during periods of feeling mentally unwell. The absence of local knowledge about mental health issues combines with limited awareness that a GP might be able to assist when people are sad, upset, angry, unfocussed, disconnected or whatever might be the symptoms. ‘A lot of people they don't know there is help to be got anywhere, they just try and cope themselves’, comments Joanne [ER, 6/11/01], gesturing again to the obsession with being resilient. In addition, there is the suggestion that GP surgeries perhaps do not do as much as they might to advertise the fact that they can be a first port of call for people with mental health problems or, indeed, for anyone exhibiting the sorts of symptoms just listed (sad, upset, and so on). ‘You go into the doctor's surgery. There is plenty [of information] for young mothers, even for drug abuse and alcohol abuse, but you hardly see mental health’, remarks Simon [ER, 19/11/01], and this is an observation that the present research team can corroborate from our own experience of Highland GP surgeries, certainly in the more rural and remote localities. Indeed, our impression is that GPs were hesitant about putting out in their surgeries our own project leaflets inviting anyone who might be interested to get in touch with us.

Once people have accessed their GP in respect of mental health issues, they may be given medication and monitored by their doctor, or they may be referred on to CPN services, day centres, psychiatrists or even psychologists. To whom they are referred will depend partly on *where* they individuals are located, although ideally as full as possible a range of specialist mental health services would be available in every locality, wherever located. For those people in remote areas, particularly North West

Sutherland, a CPN referral may be *all* that is available (this was the case when this research project took place as there was no dedicated psychiatrist for the area, not even a *locum*). In Skye, people may be referred to the CPN team or to the fortnightly out-patient island psychiatric clinic run by a psychiatrist who is usually based in Inverness. In Easter Ross, people may be referred to the community mental health team, to CPNs attached to a GP practice, or to the TDH. The geography of service provision thus has a huge impact on access to mental health care, and shortly we will examine in more detail user perceptions of this uneven geography.

Continuing the theme of limited information mentioned above, interviewees raise concerns about how access to specialist care outwith GP and CPN services is partly dictated by knowing what is available and being able to ask for it. Although less of a problem in remote areas where provision is sparse in any case, and where there are few alternatives to the basic provisions, in other areas, where a range of formal and informal mental health services do exist, a lack of appropriate information is seen by many as a key access issue:

*You either come across stuff accidentally or you know somebody, there isn't a structure from my point of view. Each individual has a different story in here [a drop-in] about what was on offer, when it was on offer [and] if it was on offer. I'm not saying everyone wants to be compartmentalised ... but there isn't any consistency on what is offered to you. [Clara, ER, 27/11/01]*

For others, once having accessed and received help from a GP, they can still experience a lack of information that impedes their knowledge of what specialist mental health services are available to them:

*You never got explained to you what services were available. [Simon, ER, 19/11/01]*

*I think they are not clear. I haven't seen much about how they sell themselves. I think you tend to get referred there or find out about it through the CPN [about day care]. ... I found it surprising that I didn't know about it at all. ... I think it could be a good resource and I am sorry I don't know much about it. There are so few resources anyway. [Clara, ER, 27/11/01]*

*I would have liked if my GP had told me what services were available. I found out more about what services are available since I've been to TAG and I found out about TAG at the Eastgate shopping centre. [Melissa, INV, 14/6/01]*

For some users, then, referral on to other appropriate services is not forthcoming, partly through a lack of information that disempowers individuals who are not then able to discuss with their GPs or CPNs possible alternatives to the care that they currently receive. As many state, more information is crucial to securing appropriate service access, both formal and informal:

*I would have found a TV advert helpful ... even if there had been an advertisement with a number you could phone if you wanted information or a leaflet. Brochures went, you went to the doctor, leaflets to pick up. There was nothing. In fact I don't think there is anything about mental health,*

*nothing to take home and read when you are in that state of mind.* [Jodie, ER, 1/12/01]

For some people in areas of more dense service provision such as Easter Ross and Inverness, relatively co-ordinated circuits of information between formal and informal service provision can make access issues easier for potential service users. Even when not in crisis, interviewees elsewhere who are routinely trying to get hold of their CPN can find access difficult:

*A couple of times I have picked up the phone to speak to the CPN team and I got a recorded message. I left a message once and it was two days before I got a reply, I realise they are very busy, [but] I'm sure that would have been the experience of a lot of people. To get a recorded message really says it all, it makes you aware of how important you are and where you stand. That needs to be improved.* [Phillip, SL, 9/8/01]

Very often, reliance on GP appointments, occasional CPN visits and repeat medications is the norm, especially in remoter rural areas. Further on we will explore in more detail users' views on GP and CPN care specifically in terms of mental health, but for now we privilege users' comments on how formal services often fail to act as a gateway to other forms of mental health care provision.

#### *Uneven geography of mental health services: distribution and coverage*

There is clear user recognition that the provision of mental health service is patchy, tied in with the sheer geographical scale of the overall region, as one user reflects with reference to psychiatrists: *'yeah, and Alness, I think they do Tain as well. It's quite a big area that this psychiatrist has to cover, the Highlands'* [Jack, ER, 16/11/01]. What users also realise is that some localities seem to provide more services, a greater range of services and perhaps too a better quality of services. *'I think some local areas actually seem to achieve a lot more'*, notes Miriam [ER, 13/11/01], thereby acknowledging precisely this variability. Such views are explored further in our findings paper on **Spatial differences**, with which the present subsection of this paper might usefully be read.

In general, we found that users identify an east-west divide in mental health service provision, it being easier to access and to utilise services in Inverness and Easter Ross than it is in either Skye and Lochalsh or North West Sutherland. *'Everything seems to be on the east coast, there doesn't seem to be anything on the west coast'* [Connor, NWS, 16/7/01], while another user, reflecting in surprise on the suggestion that even some east coasters are unhappy with the availability of services on the east coast, remarks as follows:

*That's interesting isn't it. Because I mean I automatically assume that the services are dense enough, if you like, enough variety, enough alternatives in that part of the world that that shouldn't be happening there.* [Lisa, NWS, 11/7/01]

Connor [NWS, 16/7/01] follows up his observation about the east-west divide by musing, *'... I mean, Inverness, Golspie I think is the main area ...'*, the reference to Golspie perhaps being spurred by it being the home of both a National Schizophrenia Fellowship (NSF) drop-in and a TAG unit. Meanwhile, Miriam [ER, 13/11/01],

commenting on Easter Ross, declares that *'I mean, to be honest, we've got the mental health team, we've got the travelling day hospital, you know we've got a lot more services than anywhere else in the Highlands, other than Inverness I would say'*. What is stressed by most users is that Inverness, as named by Connor, is where the majority of services are located, and one user is unequivocal about this concentration in Inverness rather than anywhere else in the Highlands: *'As far as mental health provision goes, if you don't live in Inverness, forget it!'* [Phillip, SL, 9/8/01]. Yet another user, comparing Inverness with the rest of the Highlands in terms of mental health services, simply states that *'It's a lot better than the rest of the Highlands'* [Danny, INV, 14/5/01]. Presently, we will repeat a number of complaints from users about having to travel long distances to access services in Inverness, an additional indication that Inverness is indeed the 'centre' of such services for the whole Highlands region.

Conversely, numerous interviewees point to the paucity of services in the western study areas. Speaking about Skye and Lochalsh, for instance, one user runs together comments on health care in general on the island with comments about mental health provisions:

*The health care in general in Skye is very poor ... . The area of mental health care has to be put in a broader context in any area. As far as primary care goes in Skye, it is pretty diabolical and I can say that through comparing it to another area, another rural area, so it should be similar. Skye and Lochalsh and the Highlands have been neglected by successive governments for years and years. The philosophy is 'well it's up in the Highlands, serves them right for living up there'. Consequently they have been asked to accept a second class service.* [Phillip, SL, 9/8/01]

Another user agrees, saying that *'CPNs pretty non-existent because you've only got the one real CPN here. Then, there's the psychiatrist, that's no good. No, for the size of the area ... . There's no psychologist'* [Cameron, SL, 25/9/01]. With respect to North West Sutherland, virtually all of the remarks circulate around the CPN service, given that *the* CPN – the only one serving the whole area at the time of the research – *is* in effect the psychiatric provision for this rural and extremely remote part of the Highlands. Despite it supposedly being the case that a psychiatrist would be serving the area, visiting to hold regular clinics in different GPs surgeries, in practice this is not really happening. One psychiatrist, based on the east coast, had performed this role for a while, but had seemingly refused to continue doing so; *locums* were apparently appointed to cover this job, and had held occasional clinics, but with nothing regular or involving sufficient continuity to make it a worthwhile exercise; and, as such, the one CPN has indeed been left as the only specialist service. It is true that some of the users from this area speak highly of the psychiatrists who they have seen over the years, but it is also true that they are the ones who most often had to travel outwith their area if they needed to see a psychiatrist urgently between clinics. For users in both of the western study areas, moreover, a great deal of travelling is almost always necessary to see specialist psychiatrists (such as ones specialising in addictions, children, dementia, and so on) or other specialist services (psychologists, counsellors of various sorts, and others). We will return to the theme of travelling in a moment.



Related questions arise about the mental health service coverage *within* individual Highland areas, and in particular about the situation where, rather than the user attending the service, the service is supposed to come to the user. One user from Skye and Lochalsh, drawing a comparison with Dumfries and Galloway in southern Scotland, suggests that in Highland districts it may be peculiarly difficult to create a successful ‘visiting’ service: *‘That’s a comparison ... between Dumfries and Galloway and here; they would come to your house and see you. I don’t know if it’s the locations are so far flung here, it’s such a big area, it’s not possible to see people in their homes’* [Phillip, SL, 9/8/01]. The ‘visiting’ issue is most commonly raised in relation to CPNs, for whom travelling to see clients is a crucial part of the job, particularly in the more rural and remote localities. We want to emphasise here just how *appreciative* the vast majority of users in such localities are of the CPN service, and in the context of other findings from our project – notably to do with the culture of reserve present in many places, meaning that kith and kin cannot be an emotional support or even an ‘ear’ to listen (see our findings paper on **Highlands economy, culture and mental health problems**) – the value of a CPN who can ‘be there’, who can listen and offer quiet counsel as well as suitable medication, simply cannot be underestimated.

Eleanor [SL, 20/8/01] believes that every effort is made to provide a CPN service to anybody needing it, wherever they live:

*I suppose, wherever you are, you’ve got access to a nurse, however remote you live, somehow or other. I suppose if you haven’t got any transport, there’s no transport, they’ll come out to you. I suppose you’ve still got those sorts of things available to you.* [Eleanor, SL, 20/8/01]

This is certainly the ideal, but it cannot be denied that the precise localities to be covered by a CPN service *do* make a difference to what can be achieved. As indicated, across the Highlands it is in North West Sutherland that the CPN service appears to get most stretched, and users are in no doubt that the ‘geography’ here is responsible for causing the service to be so stretched. The size of the ‘catchment’ and the sheer distances involved in moving around this catchment are both fully recognised by users, which means that, even if the CPN’s case load is a little smaller than that of most other CPNs, it is extremely tough for her to provide the kind of coverage and responsiveness that is feasible elsewhere.

Users realise that the *one* CPN cannot be visiting them all that often or for all that long when she does, and they know that she cannot be expected to act as anything like a ‘rapid response’ unit when they go into crisis. Some telling remarks in this connection run as follows:

*There were nae psychiatric nurses in this area then. ... They come every fortnight like. ... There’s a lot of vacant ground in between like.* [Jason, NWS, 19/7/01]

*Fortnightly [the CPN would visit]. She’s got such a large area to cover that she just cannot cover anything else.* [Darren, NWS, 18/7/01]

*I mean she covers a very big area. ... In all honesty, I really do think it’s disgusting that they’ve only got ... [CPN] covering such a large area, because depression is happening every day. ... She’s got this, you know so*

*many communities to go round. You know, and it's not fair on her to do it on her own.* [Stephanie, NWS, 17/7/01]

*Because [the CPN] is covering such a vast area, you might have a problem that comes up out of the blue and you can't get hold of her, through no fault of hers, simply because she might be in Lochinver, she might be in Tongue, or Durness or wherever. And, or she might be in Golspie in a meeting, or, you know.* [Deborah, NWS, 11/7/01]

It should immediately be underlined, though, that the perception of the service being provided by the North West Sutherland CPN is almost entirely favourable, the overwhelming sense being that she is performing an excellent job in the face of considerable adversity. However, there are surely significant policy implications wrapped up in such statements from users about their CPN.

Users show insight into other problems facing mental health services in the more rural and remote places, not least of which is the one of recruiting and retaining sufficient numbers and quality of trained professional staff. There is an acknowledgement that places such as Skye and Lochalsh or North West Sutherland are unlikely to be attractive to most professionals, precisely because of their 'off the beaten track' character, and the unfortunate perception remains – rooted in historical associations, notably that equating urban clinics with progressive psychiatric medicine and rural asylums with a backward 'care and shelter' holding operation – that such places are *not* where the most talented mental health professionals are found. Our interviews with service providers perhaps brought out this issue most forcefully, but users can evidently see it too, as in these two quotes from residents of North West Sutherland: *'That's something like professionals are not quite so easy to get hold of, it might cost a lot of money, and who'd like to come into areas like this?* [Jessica, NWS, 18/7/01]; *'And, then, where would the staff come from?'* [Seamus NWS, 9/7/01]. Another user from the same area hints at frustration about high levels of staff turnover, and at the link between this turnover and the fact that an area with a spread-out population, rendering day-to-day management of a service both tricky and tedious, may well not promise the kinds of 'opportunities' (perhaps for therapeutic innovation) as elsewhere:

*I think there is a need for some stability ... . The CPNs or psychiatrists could advance within the same job – so it is not always the case that if you need to advance that you have to change area – because I think the changes in staff cause more anxiety to patients than any other single issue ... but once again with the population spread as much as it is – it is more difficult to manage it – to provide opportunities for staff.* [Josephine, NWS, 4/7/01]

Again, there must be policy implications here in how to make mental health work seem more appealing, challenging and worthwhile in remoter and rural localities.

Contained in many remarks from users are visions for how mental health services across the Highlands, but particularly in the remoter and rural localities, might be improved, in effect by seeking to smooth our unevenness in provision. A general statement of what might be done is given by Gary [ER, 12/12/01]:

*[A region] such as the Highlands is a very large area and a very diverse area, it would be a good idea if we had more outreach projects and had*

*more nurses [CPNs] coming out and maybe doing a clinic or something within the village.*

More specifically, and echoing other users in North West Sutherland on the subject of CPNs, Stephanie [NWS, 17/7/01] suggests that *'they should at least have two if not three different people to cover all the areas what [the CPN] is covering'*. A few users speculate on the advantages of making available a greater variety of services across the Highlands, and it is clear that there is some demand for psychologists and counsellors. Jessica [NWS, 18/7/01] voices this demand, and it is interesting that she asks for a professional counsellor stationed locally, not in, say, Inverness, so as this individual does not end up being stressed out by the travelling:

*... I knew I wasn't fit to be driving down country to find a counsellor. And, if they could've got a counsellor in this area, I would have been happy to go to a counsellor. ... [S]o if they have a professional counsellor on the books, I don't think it would do any harm. I think it would do a lot of good, especially one based in this area that wasn't hard pushed, so you're not driving half your job. [Jessica, NWS, 18/7/01]*

This being said, many users are under no illusions about the difficulties of creating a more comprehensive mental health service in the remoter rural localities. Population levels are below the normal thresholds set for deciding whether or not it is financially viable for certain services to be provided, particularly ones requiring fixed locations such as offices, day care facilities, crisis beds and the like, and users hence accept that they may have to travel to attend such services:

*But in a very small place like this, you wouldn't really get anything; there probably wouldn't be many people with mental health problems really. But in Portree [the largest centre on Skye], you've got the Cabin, they've got enough people coming and going to Portree, so I suppose anybody here [with mental health problems] would just go to Portree. [Eleanor, SL, 20/8/01]*

*... there's the question of this population being spread out as it is. ... Bettyhill is just not big enough for something like that [a drop-in]. ... I would have to [go to] Thurso ... . [Josephine, NWS, 4/5/01]*

Interviewer: *What is the main difference between here and the city?*

Gareth: *Well, you get more user group and day care centres and things like that in a city. There's not so much in a rural community. I suppose there's not so many patients, so it's not worth funding. I mean, I go to a place once a week in Thurso, that's run by Caithness Mental Health Team, it's a drop-in centre, so I go there once a week. [Gareth, NWS, 2/7/01].*

There is then the worry of having professionals who are under-employed for long periods of time, specifically individuals waiting 'on call' ready to head out to wherever in an area someone might be going into crisis: *'Yeah, well, I mean you can't have a CPN and a psychiatrist sitting on call ... . You know, it would just not be practical. You'd have to have one sitting on everybody's doorsteps in some of the areas'* [Miriam, ER, 13/11/01].

### *Travelling to mental health services*

*'I don't know whether that's a social problem, you know, being remote, being away from all these kinds of services',* says Connor [NWS, 16/7/01], thus emphasising that a serious problem may indeed be arising in much of the Highlands because of the remoteness, the distances, between many users and many points of mental health service delivery. *'There's nothing here ... there's Thurso, but it costs you money in the taxi ... you can't get in, can't afford to go. You just have to get on with it',* adds Siobhan [NWS, 5/7/01]. What this latter quote reveals, moreover, is the connection between the paucity of services in a locality such as North West Sutherland and the unavoidability of residents with mental health problems having to travel long distances if they wish to access such services. It also suggests that the distances involved may prompt some individuals *not* to bother, particularly because there may also be subtle pressure being put on them by a Highlands culture of resilience 'just to get on with it' and not to complain, seek help or want specialist interventions (see our findings paper on **Highlands, economy, culture and mental health problems**). Covering the distances required is undoubtedly tough because of time and money constraints, particularly if dependent on public transport, and it must be remembered that many people with mental health problems are relatively poor with no access to a car (even if they are well enough to drive one). This means that the travelling issue is absolutely key when thinking about mental health care in remote rural localities that are very spread-out (see our findings paper on **Remoteness, rurality and mental health problems**).

A host of quotes show the problems that people experience if they need or choose to access mental health care, whether this be to attend a clinic with a psychiatrist or a psychologist held in a 'nearby' GP surgery or, more problematically still, to attend specialist out-patient services in hospitals, clinics or offices on the east coast (notably in Inverness). Michelle [INV, 11/5/01] states that *'I think the Highland is unique because of the area, you have a city and such a big rural area to cover in the Highlands: transport costs'*. Distances to GP surgeries and general health care facilities are mentioned by some users: *'... the distances if you wanted anything, doctors' appointments and Belford Hospital, it's about fifty miles away, or Inverness ...'* [Gordon, Inv., 14/5/01]. Distances to drop-ins are mentioned by other users, with the Cabin at Portree on Skye receiving particular reference in this respect: *'I mean you can get up to Broadford on a mini-bus, but I mean you have got to stand about in Broadford and wait for the connection to go to Portree, where the outreach, the Cabin, is. I mean, that is a ninety-mile round trip for me'* [Daniel, SL, 15/8/01]. Morag [NWS, 11/7/01], reflecting on the distance issue when it comes to specialist mental health services of different sorts, admits that *'... I still think if there was something nearer, then I would try and go to it'*.

Users worry about distances and travelling in the context of west coast people having to access east coast mental health services, from Thurso in the north to Inverness in the south:

*The psychiatrist offered me help in Thurso. She said I could attend there. Not that I want to attend them actually. But she did offer me facilities in Thurso. But you see, that's thirty-fourty miles away. And that would involve my husband coming with me and coming back because sometimes I'm not able to drive. I can drive sometimes, but not always. I get sort of in a bit of a*

*stew. So you know, it was very kind of her to offer, but in fact I had decided that I was getting too much support for my own good really.* [Charlotte, NWS, 10/7/01]

The next few quotes further underline the importance of what might be called the Inverness-Golspie axis of mental health provisions, which is many miles away from the homes of west coasters: *'I don't know how far off it is, but it is quite a distance'* [Connor, NWS, 16/7/01]:

*You saw the psychiatrist, the first time I was seeing her was down in Golspie. Well, you know, that's such a long way, and no immediate input, no ... there's no help really apart from [CPN]. You know the psychiatrist is such a long way off, I've changed psychiatrist, and he's now out in Wick. Again, it's so far away, and although they come once every three months, that's not very often.* [ibid.]

*... och, yeah ... when I was under [the psychiatrist], I had to travel to Golspie and couldn't be bothered travelling a lot of times.* [Lorraine, NWS, 5/7/01]

Fred: *But I seen a psychologist, well three different psychologists over probably five or six years.*

Interviewer: *Do they come here or do you have to go and see them?*

Fred: *I would have to go and see them, too.*

Interviewer: *Where would they be based?*

Fred: *I would have to go to the east coast, either Golspie, Dornoch. I sometimes went to Invergordon.*

Interviewer: *So there's a lot of travelling?*

Fred: *It's at least sixty miles, well one hundred and twenty there and back.* [Fred, NWS, 24/7/01]

*... all there is really like the nearest service once a week is the Travelling Day Hospital which is in Alness. Geographically, that's about twenty miles away from me.* [Gary, ER, 12/12/01]

*A couple of months ago my wife and I, out of desperation, I was becoming ill again, my wife said 'you know you can't go on like this, maybe if you say you will travel to Inverness, maybe you will get seen there'. They were saying getting people out here, big problem. So, lo and behold they did actually say come up to Inverness. By that time, I would have been reliant on my wife taking me, we've only got the one car, to take me there, it's one hundred and thirty miles away. There is no public transport ... that would have been a whole day for a one hour session. I would have done it, but there is no public transport. Also I have a problem dealing with the public, actually getting on a bus would have caused me so much anxiety that any help I got from the session would have been counter productive ... .* [Phillip, SL, 8/9/01]

The lack or unaffordability of public transport is evident from the last quote, as too is the possibility that being compelled to use public transport for journeys to mental health services may itself be therapeutically counterproductive. A footnote to the above quotes concerns the fact that, insofar as there is perhaps some choice of

services available on the east coast, precise distances and also road quality may be an influence on exactly which ones are selected (even by users from the east coast): *'Although Invergordon is very good, it's a bit easier to get from the Black Isle to Inverness than it is to get Invergordon'* [Justine, INV, 14/6/01].

Also relevant here is the matter of the distance between the homes of many individuals who have to receive periods of in-patient care and the sites of in-patient care (previously Craig Dunain and now New Craigs) in Inverness. This is a matter of concern for users themselves, who might dislike being in hospital so far away from their home and its comforts, as well as for the family and friends of users who might wish to visit them in hospital. Alistair [SL, 17/9/01] recalls that *'I needed help, but they couldn't get me into anywhere, the nearest mental health place was Craig Dunain'*; while Morag [NWS, 11/7/01] admits that, *'well, we've been visiting up here for so many years that we know how distant and far everything is. I mean, ... it's such a long way to the hospital that it's terribly inconvenient for people visiting you'*. Similarly, the following exchange is instructive: *'Interviewer: Craig Dunain hospital, it seems so far away? Gill: Yes, that's right, away from your family and everything, so that there is no support network for the person. They go away from here and that's it'* [Gill, SL, 5/9/01]. A rather different perspective is offered by another user, though, who actually talks of the benefits arising from being hospitalised at some distance from home: *'I think it was quite good for me to go to hospital in Inverness. It was away from my own surroundings. I didn't know anybody in the hospital and it's good'* [Rebecca, SL, 16/9/01]. There is hence an echo here of claims made by some users about valuing the anonymity of urban centres, as we discuss at length in our findings paper on **Remoteness, rurality and mental health problems**.

#### *Visibility: using services and matters of confidentiality*

Given the concerns of many interviewees about the visibility of their problems to local communities – see our findings papers on both **Visibility, gossip and intimate neighbourly knowledges** and **Experiencing mental health problems** – the use of formal services in rural areas is acknowledged as a difficult issue because interviewees are afraid that they will be spotted using the service *and* that those administering the service will be indiscrete:

*Well the problems of living in a small place [is] you've got the problem of confidentiality. I know all the nurses who work in the local practice. So it is inconceivable that it wouldn't get out if I had expressed problems of sleeplessness or depression. Everyone know everyone else, that's the problem and that's why people are reluctant to seek help for things.* [Phillip, SL, 9/8/01].

While these general fears exist, particularly in remote areas, most interviewees still acknowledge that they can trust service providers themselves, *'you know you can talk to [the CPN] about anything and it's not going to go any further'* [Melissa, INV, 14/6/01]. While feelings about confidentiality complicate the issue of service use, it is the visibility of service use that is therefore most problematic for interviewees in rural areas. Although this particularly applies to the use of informal services such as drop-ins (see our findings paper on **Drop-ins**), there are implications for formal service use:

*As soon as you walk in the door of a place like this, you are identified as having a mental health problem ... . There's nothing discrete about it ... because it's such a small community.* [Alness group discussion, ER, 23/11/01]

While many formal services organised through CPN and GP appointments do not require the entry to a specific building for mental health purposes, there are implications for the use of formal services like the Travelling Day Hospital (TDH) (particular to rural Easter Ross) and the Training and Guidance (TAG) units and schemes (see below). In the case of CPN appointments at local GP surgeries, even the visibility of the waiting room can cause some interviewees concern about the uptake of psychiatric services:

*I was in the doctors waiting for an appointment with the CPN and two or three of the local gossips were in the waiting room as well, and the CPN came through and shouted my name and I could see the others going ... you know. It was so difficult as you knew fine they would be going 'what's she doing?'. I was very aware of that.* [Clara, ER, 27/11/01]

For others, it is community knowledge of a service provider's car that causes most concern about visible service use, as close neighbours may well be able to identify when psychiatric workers come on house calls:

*They see [the CPN's] car at the side of the road, so they put two and two together and make four. They know the CPN's car. You know every car that's around here.* [Darren, NWS, 18/7/01]

*When it was first suggested that the CPN come and see me, I wouldn't let her come, as I was frightened that people would see her car outside and they'd all think I was dippy.* [Natasha, NWS, 17/7/01]

The use of CPN services for people with mental health problems in rural communities is expanded upon below, but what these quotes do more broadly is signal the huge issues facing rural residents in their decision making about service access.

Interestingly, interviewees point to differences in service uptake between different members of the community in relation to issues of visibility. For example, incomers are identified as being less concerned about issues of visible service use:

*There are some workers on the west coast and if you use the words 'mental health', ... then forget it ... no one will come near, no one will use it [the service]. The first people who would use the service are incomers who are used to being able to access services and specifically mental health services, whereas the locals ... there was a big stigma about accessing it.* [Alness group discussion, ER, 23/11/01]

While there are many dimensions to the relationship between incomers, locals and mental health issues (see our findings paper on **Social differences**), it may be that, as incomers are often already considered 'different' in small Highland places, there is a sense that they have somehow 'less to lose' by accessing such services than do local people. One local user in the Northern Highlands sums up this point:

*... well, if they were incomers, they'd probably be treated differently anyway. 'Oh, they're different'. ... They're from a different culture and, if they're emotional, that's because they're English or Welsh or Irish or American or whatever. They would be put into a category. [Deborah, NWS, 23/7/01]*

Although there are many contextual factors that affect service use for all sorts of different groups in rural places, rather than explore these in any more depth (see other findings papers), the document below now lays bare what interviewees feel about the services that they *do* use, as well as pointing to what they feel are the key gaps in service provision.

### **User views on psychiatrist services**

Many of our interviewees have seen a psychiatrist as part of their mental health care experiences. Most see their psychiatrist infrequently, say, every three or six months, with some people increasing their visits to weekly, fortnightly or monthly should they be experiencing particular difficulties or changing their medication. Hence the role of the psychiatrist is one of a distant but powerful figure in the everyday lives of most mental health service users: *'you've only got about ten minutes. I think they just want to see me in normal land really, Just make sure the medications in order'* [Julia, SL, 17/9/01]. Several different psychiatrists prescribe medication for many people in Skye, Easter Ross and Inverness. In North West Sutherland, at the time of the research fieldwork, there was a vacant post for a consultant psychiatrist, so none of the interviewees had this service input. This was something that the local CPN was very concerned about as effectively she, along with local GPs, was prescribing psychiatric medication without consultant psychiatrist advice and support (although *ad hoc* guidance could be obtained from New Craigs in Inverness over the phone). These different contexts inevitably shape the response that interviewees give regarding the significance of, and their feelings towards, psychiatrist consultants.

Those in North West Sutherland were asked to recall their feelings and experiences of service provision when a psychiatrist had been in post, and most note that they had been required to travel long distances in order to access this service:

*When I was under Dr X, I had to travel to Golspie and couldn't be bothered travelling a lot of times. [Lorraine, NWS, 5/7/01]*

*The psychiatrist, the first time I was seeing her was down in Golspie, well it's such a long way and no immediate input ... there's no help really. [Charlotte, NWS, 10/7/01]*

For some, when they were feeling ill and unable to travel, this service was effectively unavailable (see also section on travel to services above). For those in other areas, psychiatric consultant was available in clinics (fortnightly in Portree, Skye), via mobile services (the TDH in Easter Ross) or in hospital sites (Inverness). Although in many accounts the psychiatrist merely represents someone who prescribes medication, for some the relationship with the psychiatrist is something more:

*Dr Y thought it was better for me to live in Portree. [Hazel, SL, 13/8/01]*



*It's important to see Dr Y if you have something on your mind you can talk to him about it. I tend to tell him more ... . [Ralph, SL, 18/9/01]*

As psychiatric consultants are thin on the ground in rural areas, good relations between provider and client are important, since for most rural residents there is no second choice should they be dissatisfied with the service. In some areas there may only be one psychiatrist serving a very large area for years at a time:

*I think we have one psychiatrist here. I think if we had a couple ... the folk that don't click with Dr Y would have someone to fall back on. [Collete, SL, 19/9/01]*

*I've got a psychiatrist who is an arrogant young man who does not want to listen. [Julia, SL, 17/9/01]*

*The [only] psychiatrist will no take me on 'cos I told him what I thought of him. [Cameron, SL, 25/9/01]*

In other rural areas, quite the opposite problem is noted by interviewees, who find themselves to have a major problem of continuity with respect to the relationship with a particular psychiatrist:

*One thing I would like to say is the continuity up here in the psychiatrists for this area is terrible. Generally [you get] locums and then you get a registrar. You don't get to know a psychiatrist very well. [Keith, ER, 16/11/01]*

In rural areas it may be difficult to attract psychiatric consultants who are able and willing to commit to serving large remote geographical districts for any length of time. As several users suggest, it may be that more efforts need to be made in making such career choices attractive to highly qualified mental health workers.

Relations with psychiatrists are very significant, even if they are somewhat distant figures from everyday coping mechanisms and strategies for most rural residents. For some people, ones who had perhaps lived with hidden problems for a very long time, the first meeting with a psychiatrist can be immensely important. This may be especially the case in remote rural areas where there can be little local expertise amongst GPs and no opportunities for people to discuss their feelings and experiences with others:

*So I saw a new psychiatrist. And I was only talking to her for about half an hour and she said 'I think you're suffering from OCD'. 'And everything that she said about OCD ... it was like she was telling me my life story, the first time I saw her, in half an hour. And for someone to tell you what you've been hiding from the rest of the world ... . I hid it, well the bad part of it, for probably four or five years. And it was really bad. And then to meet somebody and them to tell you what you've been doing, what you're hiding was a bit of an eye-opener. But she could tell, she was telling me what I was thinking. There was a pattern of thought that I would have, and it was. She knew. So ... since, from the day I met her it was probably ... it was probably seven years to today, it's been gradually ... I've been getting better to today. [Fred, NWS, 24/7/01]*

The significance of first service contact is perhaps greater in areas known for problems with service uptake and access due to cultural and social stigma. At the same time, it should be acknowledged that first service contact is also important for those people who have existing mental health problems and have migrated to the Highlands, and for whom the change in psychiatrist provision can prove daunting:

*I was lucky down south with my psychiatrist and so it's quite difficult coming up here ... I haven't seen my psychiatrist and I find that difficult to cope with ... changing psychiatrist again and to one that is so far away. Almost as if I am one added on the end and not part of what he does and so I think I'd like more. [Charlotte, NWS, 10/7/01]*

In this case, the migrant had recently moved to North West Sutherland where there was no consultant psychiatrist in post at the time, although alternative arrangements had been made in this case. For former urban dwellers, who may have had more frequent access to psychiatric services of all kinds, it is perhaps important that a positive first contact with a psychiatrist is made quickly in order to prevent unnecessary anxiety or a decline in mental health.

### **User views on CPNs**

While psychiatrists are important to rural dwellers, they are not deemed as important by our interviewees to everyday coping management strategies and community living as are CPNs and GPs.<sup>2</sup> Service users in all four case study areas have access to CPNs, although only some are actively participating in this form of service provision at the time of the research project. Strikingly, the CPN service is most crucial to users in North West Sutherland, as this was the only area without any other form of service provision (lacking a psychiatrist, day centre or drop-in). Likewise, in remote parts of Skye and Easter Ross the mobile nature of the CPN service is taken as particularly helpful, providing those who are unable or unwilling to leave the home or travel far from their place of residence with some source of mental health care and support. For people in Inverness the CPNs seem less important in their landscape of care, given the availability of other informal and formal services such as day centres like Ross House and Bruce Gardens (where CPNs could also monitor and contact patients on a daily basis).

In North West Sutherland in particular, but also in remote parts of Skye and Easter Ross, the CPN has a major role to play in the everyday coping strategies of people with mental health problems:

*I couldn't wait for [the CPN's] next visit to come. I just, I mean at that point she was coming on a Tuesday. And I mean by the next Thursday after she left I was just trying to grab the Tuesday and pull it forward, even though you knew you couldn't. I just couldn't wait, because something would happen, or something would be going through your head or whatever, and you'd think 'oh god I wish [the CPN] was here', so I could speak to her. [Stephanie, NWS, 17/7/01]*

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<sup>2</sup> Social workers who specialise in mental health work also figured in the service landscape of some interviewees, although views on these services were not significant across all four areas (partly as a result of under-provision in some areas), and hence this service is not discussed here.

The importance of this service in rural and remote areas is partly a function of a lack of other services (as noted above), but also a function of the social and cultural *milieu* in which clients find themselves. As we have noted in other findings papers, rural and remote Highland communities are not always culturally conducive to talking about mental health difficulties and thus gaining support, even from family networks:

*It's just that sometimes she feels like the only support I've got.* [Louise, NWS, 5/7/01]

*The CPN is the only one I feel understands me.* [Siobhan, NWS, 5/7/01]

The reliance on CPN services as a medium for general discussion about social situations and routines in everyday life is as important for many clients as are discussions and negotiations about medication. The need simply to share experiences of mental health problems is most prominent in interviewees' accounts. Hence, the CPN, as someone who listens and talks about mental health, differentiates this person from other community members, who often avoid such conversational topics. The role of the CPN is noted by interviewees as one intended to provide support for community living, at the same time as not encouraging over-dependence on the service. However, the lack of other forms of service provision and cultural opening to share experiences of mental health difficulties in remote areas means that clients are perhaps disproportionately needy of these services.

The CPN's role is further defined by interviewees in particular ways, notably as being key in supporting them through re-integration into community life after periods in hospital:

*The doctor's responsible for setting me little tasks, little goals to achieve, the CPN is there for backup and comes out to see me once a month, it's been cut down to now. At first when I came up here I thought I might not be able to see my CPN anymore. It's quite like having a cushion, a rebound barrier, having someone who will talk to you as a person and see how things are in general plus any specific areas you might not be sure about.* [Clare, INV, 14/6/01]

*Well, she's just like a ... she helps me in the community, like I was saying. I found it very hard to fit back in again, that's what I was saying about effort. So [the CPN] is there to help me. In fact, you get negative thoughts, you know, and [the CPN], you know, she's more positive thinking.* [Connor, NWS, 16/7/01]

*It's quite nice having a nurse come around – because you get used to nurses in hospital so it's sort of continuity.* [Rowland, NWS, 5/7/01]

Beyond assisting with re-integration and re-establishing everyday routines that are appropriate to the community and not the hospital, the CPN's role as a counsellor figure is important to many clients. Although not all CPNs are noted for their counselling skills – some are only referenced in relation to medication monitoring – for many interviewees the discussions held with these service providers are seen as a crucial means through which the negative aspects of mental health problems and rural community living can be rationalised and diminished. The value that interviewees attribute to CPNs is partly related to their expert functioning, but also to their ability

to talk about mental health issues in an informed way: *'she knows more than the actual doctors'* [Connor, NWS, 16/7/01] and *'I just see the CPN in a counselling capacity if you like'* [Sophie, SL, 8/9/01]. For some interviewees, the CPN service acts as a reassuring bedrock of support upon which they themselves build: *'[the CPN] is a back up, to help me go on forwards'* [Connor, NWS, 16/7/01].

The support that a CPN offers is noted to be qualitatively different from other support in the community, such as from friends or family. In part, this is related to the content of CPN-client meetings, where distinctive types of 'vulnerable talk' can take place:

*I look forward to seeing [the CPN] if perhaps there are things that I feel I can't discuss with my family. I look forward to having that opportunity.* [Sophie, SL, 8/9/01]

*I just tell [the CPN] everything, she's here to listen, she doesn't judge me and she is always ... I would be lost without her to be truthful. I know she is there, it's like a safety net for me and I can phone her if I need her and she is just there. The family now, you just can't phone them if you need them I feel, I could before but I just can't now. I have told [named CPN] more than I have told anybody.* [Siobhan, NWS, 5/7/01]

Talking to family and friends who perhaps do not fully understand the experience of mental health difficulties, or who are disturbed by discussion of continuing problems, presents problems for some interviewees. There is hence a strong sense that talking with CPNs constitutes extremely valuable time, crucial for those people with no other outlet or opportunity for discussing their vulnerability: *'He listened and you didn't feel stupid. Talking to anyone else about it, we felt that people didn't want to know our problem'* [Leo and Katrina, ER, 6/12/01]. Some clients explicitly express the difference that talking with CPNs could make:

*He wouldn't solve my problems, nothing would be changed when he walked out that door, but I would look at the problem differently. And that was what he was able to do. That's a big thing, it's a gift.* [Fred, NWS, 24/7/01]

For some people in rural and remote places, the need for this service is acute, especially when clients may not have had any other service input in terms of hospital or psychiatric consultation: *'I remember sitting at the window, hoping that their car would come. Hoping for him to do this for me [make me well]'* [ibid.].

When experiencing mental health difficulties, there is a tendency for some people to withdraw from everyday spaces of social interaction, and for these clients the CPN service is significant in helping them to re-enter these geographies:

*If she's got time we'll go out and have a hot chocolate somewhere or go to the pottery and things like that. I do find going out quite difficult. And then when she's not got much time we just talk in here. But, as I don't get out that much, it's quite interesting to go out with her even though I'm tense all the time I'm out.* [Morag, NWS, 11/7/01]

The CPN service in remote and rural areas thus carries many meanings and fulfils multiple roles for clients in terms of medication monitoring and prescription, as well as through various kinds of counselling and support work. Combining these roles is

challenging for stretched service providers, and there is a sense that in remote areas these roles could not be carried out fully (see below).

Despite the difficulties in providing such mobile psychiatric services across vast areas and long distances, it is valued by many interviewees that visits take place on their home ground:

*In one way it's better because [the CPN] comes to me and we meet on my territory and it's less formal ... . Sometimes when the sun is shining, we sit outside on the garden ... on the grass and talk about things. [Josephine, NWS, 4/7/01]*

Discussing everyday difficulties and emotional problems may be easier for clients in the familiar surroundings of their own home, rather than in a formal office, and so it gains a distinct advantage as compared to other service delivery points. Also from the provider's viewpoint, seeing the client in their own context may be useful in developing an accurate understanding of their difficulties. Even so, while home territory might allow feelings of security and safety in some clients, for others this remains a constraining space where the presence of other family members renders it difficult to engage fully with the CPN in order to make progress (see also our findings paper on **Safe and unsafe places**):

*Every time [the CPN] came ... we had a daughter, she's away now, but she was staying at home at the time, and they always stayed with me so I could never [say anything] .... At that time, and [the CPN] was quite right, she said, 'all you need is a good blow-out. I'm going to take you out in the car, and you can really [talk]', because they were never far away when she was here so I never felt free to ... so it was just no freedom to, especially since I came up here, no freedom to unburden yourself. [Deborah, NWS, 23/7/01]*

In this case the CPN facilitated therapeutic discussion by removing the client from their home-space and driving around while they 'unburden' themselves. Such innovative ways of delivering care are appreciated by clients, who recognise the need for flexibility in terms of ways of interacting with the service provider, although this is not to say that combining such a service with the option of talking to professionals in other spaces would benefit other clients: *'if you had some place where you felt you could go, that would be a big help to me'* [Lisa, NWS, 11/7/01].

For those interviewees who live in remote, sparsely populated places, and who rarely speak to others about their problems, the CPN assumes an important role in their everyday lives, as noted above. For some the boundaries of the CPN role can be blurred, though, as they see the provider as more than just a professional and rather as a friend. While CPNs in all areas have to be aware about boundary blurring, there is evidence that client-provider friendship do occur, especially in remote places, with both parties fulfilling their community status as neighbours as well as acting on their roles as client and provider:

*She's more like a friend than a support worker, you know, she's a very nice person. [Charmaine, ER, 22/11/01]*

*Very important ... she's like a friend to me, sit and talk to her. Not friends maybe but ... . Being professional in many ways, it's easier to talk to her. Different and better feedback in some ways. [Julia, SL, 17/9/01]*

*Yes, we are, we're friends, you know, so we see each other regularly on that basis. And I suppose now we're both able to have a moan at each other [laugh] rather than me doing the moaning and her doing the listening. [Lisa, NWS, 11/7/01]*

While the former quote indicates the positive 'friendly' nature of CPN relations with clients, the latter quote indicates how such relations can stretch in rural and remote communities to encompass a 'friendship' which exists outside the roles of carer and client.

According to interviewees, one of the biggest problems with the CPN service, especially in remote areas, is the pressure on the time of the service providers and the resultant limitations that they experience in their own contact with the CPN:

*I think [the CPN] is absolutely brilliant. But I just wish she could be about, be about more often, you know, because – I'm sure I'm not just speaking for myself – but, you know, it's now to once a fortnight, and to me, because I can't speak to anyone else, once a fortnight is an awful long time, you know what I mean. But that's not [the CPN's] fault. [Stephanie, NWS, 17/7/01]*

For CPNs who cover large areas in Easter Ross, Sutherland and Skye, their clients are acutely aware of their workload and the distances that they travel to cover their 'parish'. In terms of the CPN service, this knowledge often actively affects the relationships with the clients, with some feeling that the service 'was unfair':

*She covers a very big area, but because she's on her own, you know, she's covering such a large area, it's not just fair on [the CPN] on her own. It's not fair on everybody, you know. ... A lot of people like myself don't have people who understand and you can't just speak to them. [ibid.]*

The main problem with the stretched and mobile geography of CPNs in remote areas is that clients feel sessions to be rushed on occasion because the CPN has to move on, and users regret that they are sometimes unable to gain a sense of closure on a discussion:

*And in all honesty I remember [the CPN] coming in, she'd be in for maybe half an hour .... And over that week you would have that much built up in your head what you wanted to talk about, [but] she would end up going and then ten minutes later you'd think, 'oh I wish I'd said this to her, I wish I'd said that to her', 'cos you knew it was going to be another week or so before you'd see her. [ibid.]*

However, the fact that a CPN covers these huge distances can sometimes be an advantage, as some clients feel that their CPN is not part of their local community and therefore less likely to breach confidentiality:

*You know you can talk to her about anything, and it's not going any further. She's totally professional in that. She's also not part of the community. If it was somebody who was trained locally, you wouldn't really know if that*

*information would get out or not. It's just totally confidential, and you wouldn't want it to get out. [Darren, NWS, 18/7/01]*

In relation to this point, clients are aware that members of their community may well know that they are receiving visits from the CPN, partly because service providers' cars are well recognised in sparsely populated areas (as discussed earlier):

*I would think that they know – 'cos she also comes to see the lady just down [there] - so she knows, she knows that [the CPN] comes to see me and I know that she [the CPN] goes to [the lady] ... . [Josephine, NWS, 4/7/01]*

*I know to begin with, when [the CPN] was coming to see me, I felt that inevitably people would see her car here, and they'd know who she was and would draw their own conclusions, you know. And we actually have friends who saw [the CPN] and he lives outside the village and he came to see her because he didn't want her going to the house because of that, because people would see, because it was quite sensitive from his point of view. [Lisa, NWS, 11/7/01]*

Despite the fact that people may be aware that friends and neighbours are seeing a CPN, many clients also state that they would never talk about such visits in-depth, if at all. Again, the social and cultural contexts within which such services operate dictate whether or not service user networks might develop around the provision (see below and findings paper on **User networks**).

The generally good relations between CPNs and clients in rural and remote areas translate not only into 'friendly' relations, as mentioned above, but also contribute to an active concern about CPNs and the geographies of their work:

*I've seen poor [CPN] come in here quite drained and exhausted after her day in Tongue. [Deborah, NWS, 23/7/01]*

*I know, from talking to [the CPN], that she's stretched to her limit, and then some. Yeah, I would say so. I would say that, I mean, you mentioned when we first started the amount of people who are using psychiatric services in the north of Scotland, and I would say it's quite a few. Well, I used to get two hours of [the CPN's] time, three hours at a time every week, and in the end it was me that said to her 'don't come around', because she was on the run, she was just on overtime. [Seamus, NWS, 9/7/01]*

*Yes, because she has, you know she has her own problems, like everybody does, but she also has everybody else's. I mean, I said to her, 'how can you, how can you cope?', and the traffic, and trying to run a house and keep a family together, and ... . I just don't know how she does it to be quite honest. You know, there have been occasions when I've been quite worried about her, you know, just from the point of view, the physical aspect even, never mind the mental aspect. You know, you just sort of think she physically is exhausted. [Lisa, NWS, 11/7/01]*

Here clients are openly worried about their service provider, and they actively take steps to reduce her workload by telling her not to see them and are extremely aware of the provider's own physical and mental state. Such a phenomenon is probably peculiar to remote and rural locations where clients are attuned to both the difficulties

of service provision (in all areas of life) and the challenges of daily travel across large geographical areas; but perhaps questions need to be asked about whether clients should have to be actively amending their service demands in respect of these concerns.

In most interviews, people are positive and appreciative about CPN service provision. The only notable grievances with this service were over the levels and types of medication prescribed:

*I don't agree with [the CPN] on everything ... for example ... the drugs ... . She sees it that you take X amount of drugs and it contains the situation and you're ok, instead of saying right 'we'll take you off and cut it back or take you off drugs altogether like and see how you are', ... you know what I mean? ... No one ever says 'well drop it and monitor it' ... . Too big a gamble ... no one is willing to do it. I don't agree with that, like ... she comes round every fortnight but all she says is 'take your tablets, get your blood tests'. I'm 44 and I'm no going to have a career now ... . It's not very good for the twenty-first century, is it? [Jason, NWS, 19/7/01]*

Interestingly, this client raises questions about the risks of dropping medication levels. Indirectly this suggests that, if there could be more support available to particular clients, there might be more willingness from service providers to 'take a risk'. With the problems of adequate areal coverage, however, it may be that medication provides an extra safety net for clients. Rural geographies of mental health care may hence be characterised by particular prescribing patterns, and, controversially, these patterns might differ should the same clients be located in dense urban service networks. (We should underline, though, that these are highly speculative remarks on our part, and would ideally require further investigation.)

Overall, this selection of interviewee responses to questions about the significance and meaning of CPN services highlights their crucial and much appreciated role in rural and remote service landscapes. Huge concern is nonetheless directed towards both the stretching of these services and the need for more CPN cover in such large geographical regions.

### **User views on GPs**

The importance of GPs for all users of mental health service is connected with the ways in which these service providers first respond to and identify mental health difficulties, and how they then direct appropriate treatment from this point. For people in rural and remote parts of the Highlands this is doubly important, as it is unlikely that they can easily switch GP practice or seek other forms of support. For many, the relationship with their GP is positive, especially for people who have lived in their local area for a long time. There are several elements to the relationship with the GP that interviewees identify as important in terms of the quality of the care received, and these include the listening skills of GPs, their response to mental health symptoms, their response in crisis situations, their continual support during times of difficulty, and their patience with people who need to visit the surgery often. The complications to the GP relationship are focused around inappropriate responses to mental health problems, perceived (negative) beliefs about mental health issues and lack of follow-up once problems have been established.



The relationship with a GP is a power laden one, and particularly for people in a remote and rural community setting it is deemed important to have a good rapport with GPs in order to be able to establish trust. For those people who have resided in their local area for a long period of time, that basis of trust may have been established over many years prior to mental health problems occurring:

*We are about the same age and I can relate to him very, very easily because he was [my son's] GP from virtually when I first came up here. So there is a bond there and I don't have to go in and start to explain things to him.*  
[Glenn, SL, 6/9/01]

The GP's knowledge of the patient is deemed important to many interviewees. For those who live in small communities, they are aware that the GP would have a more contextual understanding of their lives, as they would simply be more visible to him or her. This contextual knowledge is a positive attribute for some:

*He was supportive, I think also because he had an awareness, what you are saying about the sense of community, everyone, you are working in a radius where people know, there's a lot of personal contacts in a big area, in a 20-25 mile radius. So he had an understanding of the chronology of things that had happened with me, even though I hadn't told him, because it was all public knowledge of the circumstances.* [Vincent, ER, 17/12/01]

Here, then, the visibility of the everyday lives of people with mental health problems in rural areas is perceived as positive rather than negative, and in this sense community knowledge which is transferred through gossip actually contributes to the service provider's understanding of and empathy with their patient. For some patients, this sense that their lives are known to the provider in a more holistic way than would be the case in urban areas appears to help in the establishing of trust. This trust also translates into being able to confide in their GP about mental health issues, but also pivotal to this feeling of trust is the perception that patients are being listened to:

*Anytime I wanted to have a longer discussion with him, he would sit there happily for twenty minutes.* [Jessica, NWS, 18/7/01]

*She's a doctor but she is like a friend.* [May, ER, 12/11/01]

*She's dead good ... the first time I saw her ... she spent 45 minutes talking to me. She does sort of take the time to understand you rather than throwing tablets at you.* [Miriam, ER, 13/11/01]

Nonetheless, some GPs are still characterised by interviewees as not always having the necessary skills to be able to deal with people with mental health problems. The perceived role of the GP as a general and not a specific service provider hence influences the ability and desire of the interviewee to confide in them:

*You can't go to the doctor to go and talk to them ... there are no trained listeners ... what's missing is people who are trained ... the doctor can give you the pills ... but that's it.* [Frank, NWS, 26/9/01]

*I find it very hard to go and talk to the doctor. There's ways and means of making people talk, because you kind of close off if you know what I mean ... and I don't feel you get that from the doctors because I think the doctors are more physical than mental. [Connor, NWS, 16/7/01]*

*I am not used to my GP ... the relationship ... we don't spend many minutes discussing health problems. [Josephine, NWS, 4/7/01]*

For some rural Highland residents, their views on talking to GPs are also influenced by their perception of the personal beliefs of the GP concerned: *'I don't know his views on depression [therefore] I wouldn't go and talk to him'* [Natasha, NWS, 20/8/01]. GPs are recognised by interviewees to be very much part of the communities that they serve, and interviewees therefore understand that GPs do not always have 'healthy' perspectives on mental health, despite being medical professionals. Once a GP's views on particular issues are community knowledge, which can happen in small places, this may then affect consultation trends. In particular, there is a sense from several respondents that some rural GPs are acculturated to the local social norms of the area, and are thus themselves unwilling to discuss or to identify mental health issues in their patients (see also our findings paper on **Highland, economy, culture and mental health problems**). For some interviewees, this has meant traumatic experiences and inappropriate responses from GPs to mental health difficulties:

*She gave me sleeping tablets and told me to go home and take the whole bottle if I wanted to 'cos they wouldn't do much harm to me anyway - so that after coming out of hospital after an overdose ... I didn't need to hear that ... . [Lorraine, NWS, 5/7/01]*

*You just can't go to your doctor and talk to your doctor, because your doctor is a religious bloody maniac who hates your guts anyway and everyone else that you know who has a problem. [Nigel, NWS, 11/7/01]*

*I spoke to my doctor when I split up from my wife and he said 'you'll need to get down on your knees and pray'. [Alistair, SL, 17/9/01]*

In the latter two quotes interviewees highlight concerns about religious beliefs amongst some Highland GPs, which again ties in with a theme explored in our findings paper on **Highlands, economy, culture and mental health problems**. For others, relationships with their GP are made difficult by the latter's refusal to acknowledge psychiatric difficulties at all fully or to display adequate levels of understanding:

*He told me that psychiatric illness only existed in the very extreme schizophrenic and that kind of thing ... the rest it was just things they could sort out in their own lives. That's what he said. [Fred, NWS, 24/7/01]*

*You know, it was as if I'd done something wrong, and he was quite aggressive. He told me this about mental illness and he was saying, you know, he was asking me what I was worried about. I think what he was really saying was that I was a fool, so that was the extreme of what the doctors are like. He was a GP, and whether he's still practising or not, I don't know, but he was five years ago. [Fred, NWS, 24/7/01]*

*I saw this particular GP and it was just 'get your act together' ... that was the reaction I got. That knocked me back for weeks before I had the courage to make another appointment with somebody else. [Judith, INV, 26/8/01]*

There is a sense that training and education for GPs on mental health issues would result in people with mental health problems receiving a better standard of primary care. Several interviewees compare their past experiences of other GPs who were at different stages in their careers, and who had therefore had received different levels of training on contemporary mental health care and medication:

*I wasn't diagnosed when my first child was born for post-natal depression, but the doctor at that point in time, when I went to see him, was totally unsympathetic. I said 'I'm crying all the time, even when I'm Hoovering the floor'. 'You've just had a baby, you old ...'. He was quite 'old school'. 'What do you expect?'. I wasn't expecting to be crying when I'm Hoovering my floor! [Jessica, NWS, 18/7/01]*

*I mean I had it, just repeat prescriptions with this doctor, you know, and he'd never even seen me. [Natasha, NWS, 17/7/01]*

*Some of the doctors are just not well up on ... . Way back when we had the old doctor, oh twenty, thirty years ago, he had me constantly on some sort of anti-depressants, but, as I say, at that time you weren't so aware, you didn't get a leaflet with these things, and I was on them for years, you know with no [information]. [Deborah, NWS, 23/7/01]*

For some, the frustration lies with the knowledge that GPs cannot be specialist mental health service providers, and yet they are often in primary control of medication and 'therapeutic talk' for people with mental health problems, especially in areas where there is a lack of other service provision: '*they don't really understand, but they won't admit they don't understand*' [Paula, NWS, 5/7/01]. For others, the GP is an important source of information about other services and a point at which they are referred on to more specialist services:

*I know when we first joined the GP, they mentioned the Cabin [drop-in on Skye] straight away. [Eleanor, SL, 20/8/01]*

For most, though, the GP is an important constant in areas where it is difficult to see mental health specialists on a regular basis. The GPs do exert an influence on coping with everyday routines and for recognising stages in journeys through mental health problems with respect to levels of activity, being careful about medication and goal setting:

*The doctors always say, I mean I've gone to the doctor in the winter and said 'look, I'm feeling much better, I really feel I'm able to cope, you know, I think we ought to start to reduce the tablets now'. And they've said, 'well, let's give it another couple of months, Natasha, and let's get over winter', you know. [Natasha, NWS, 17/7/01]*

*The doctor's responsible for setting me little tasks, little goals to achieve. [Clare, INV, 14/6/01]*

The GP occupies an important place in the geography of mental health care, especially in rural and remote locations. Overall, users point out the importance of up-to-date mental health knowledge, while at the same time emphasising that understanding and empathy is crucial in good patient-GP relations.

### **User views on Training and Guidance (TAG) units**

Four TAG units are located in our four study areas. The units vary in size of staff, between one and five, and in the number of clients. Access to TAG is through referral mainly from GPs, and anyone who has or has had a mental health problem can access TAG. There is an emphasis on those who have recovered or are recovering from mental health problems and feel able to engage in training. Use of TAG is time limited with clients unable to return to TAG until a set period of time has elapsed. The aim of TAG is to provide a supportive environment in which those with mental health problems can develop and acquire a range of skills to aid their re-entry into employment. TAG offers a range of courses mainly focused around IT skills, while also supporting remote learning from Further and Higher Education sites (such as the new University of the Highlands and Islands). In its efforts to aid movement back into work for those with mental health problems, TAG acts as a facilitator between clients and potential employers, organising voluntary and paid work placements in the community.

Premises are located in a range of sites, with some being located in the grounds of hospitals or in local community facilities such as schools and community education units, while in some cases – notably in North West Sutherland – TAG trainers travel to clients' homes. The siting of units can be of importance for users, with Joanne detailing how the location of the TAG unit within the site of a local hospital provides an element of cover for her use of what is essentially a mental health service:

Interviewer: *How did you feel about going to TAG then?*

Joanne: *That was okay, got on the bus and got off at the County [hospital] or took the car. [Joanne, ER, 6/11/01]*

Joanne's desire not be linked to a mental health service highlights the stigma attached to such issues and the perception of being visible in rural areas (see our findings paper on **Visibility, gossip and intimate neighbourly knowledges**). The location of such units has also brought to light the negative attitudes and misconceptions of the wider community around mental health issues. One user recounts community attitudes to the siting of the TAG unit on Skye:

*The school where we have the TAG, we have realised that since we moved there, there hasn't been enough information about what we are and who we are and what we do and so on. Some members of staff there are wary of us. They say, somebody actually said to the organiser, co-ordinator, 'well you know we have to protect the children'. [Chloe, SL, 21/8/01]*

This extreme example serves to emphasise further the difficult attitudes often faced by individual users themselves. From a service provision perspective, it raises issues about the ways in which such services integrate into the community, and how to encourage users to access such services if they are aware of wider stigmatisation of TAG units and their locations.

Throughout user accounts, the complex role played by TAG in their lives is highlighted. TAG units are not simply a place where training skills are acquired, but are also where friendships are formed, self-confidence increases and, perhaps most importantly, individuals realise they are not alone in their emotional distress. This sense of commonality and ‘belonging’, at times lacking in users’ interactions with the wider community (see our findings paper on **Exclusionary Social Relations**), feeds into what we would argue is a wider ‘mental health community’ (see also our findings paper on **User Networks**): ‘I’ve made friends, I don’t actually need to feel lonely, they are there for me’ [Karen, ER, 20/11/01]:

*There’s a great lack of sympathy [in the community] for when the worst times come, the black times. But within TAG when people are going through the black times, there is a network of support amongst the trainees. It’s an empathy, you are well aware it doesn’t take much to kick you back down the slippery slope and that could be you next week. [Melissa, INV, 14/6/01]*

Despite the obvious benefits of using TAG, users recount their sense of trepidation at first accessing TAG, emphasising what a big step it is for some Highlanders to use collective mental health services:

*Coming to TAG for the first time I got to the door, went up the stairs, ... burst into tears and walked back down. I came the following week. At that point I [opened] the door and managed to come in. She said ‘sit yourself down’, and I said ‘no, no I’ve got myself in the door’, and away I went again. The first couple of months it’s quite difficult because you know this place is going to help you but you are already feeling quite insecure. [Susan, SL, 20/9/01]*

*I’d a stalker for three and half years and I wouldn’t go out my front door for a while. Then my CPN suggested coming up here. The first day I was here I was very wary you know, too shy to speak to people. But see now, everybody, it’s such a relaxed friendly atmosphere, there’s no stigma about it or anything. You feel you can be yourself more. [Clare, INV, 14/06/01]*

Through Clare and Susan’s memories of entering TAG, we are offered a glimpse at the emotional distress experienced by those with mental health problems and the problems of isolation which can result from these health problems. The changing mental health states of those who attend TAG mean that it is valued as a sheltered and supported environment in which clients have the opportunity to learn and to work at their own pace, something which is perceived as not being possible within more traditional working environments:

*Everybody’s so friendly, relaxed environment. If things are getting on top of you, you can ask a tutor for help or you can go into the wee room there and have a tea or a coffee or a fag whatever. [ibid.]*

*I couldn’t have done it if it was a job, it would have been so much pressure. Like, last week I knew I couldn’t come in but nobody shouted at me, there was no pressure. [Jodie, ER, 1/12/01]*

*Well, when you are in a working environment I think there is a natural competitiveness maybe to outdo each other or get further in with the boss.*

*There is none of that social pressure in a place like TAG or other mental health places ....* [Gerry, ER, 19/11/01]

For a number of users, loss of confidence is a facet of the experience of being ill, one which is debilitating in its own respect: *'I think it's mental illness, it's something to do with you don't have the confidence or the [ability] ... to communicate with people'* [Gerry, ER, 19/11/01]. For these people, the supportive working environment is vital:

*It was the best move I ever made, so I think I would say it was very, very important because a lot of people, it doesn't matter how minor a depression or setback you've had, it can be enough to knock your confidence.* [Sharon, INV, 27/6/01]

Sharon suggests that TAG is crucial in nurturing self-confidence, a point made by other users:

*To get the chance to come to TAG has been a life saver for me. I've achieved things I didn't know I was capable of.* [Karen, ER, 20/11/01]

*I've done most of my computer course, which I never thought for a minute I could do that. Everybody helps you out. Even though it is only a basic computer course it's a huge step for me.* [Jodie, ER, 1/12/01]

*To me before computers were a no no, you know a great thing I would never manage, and now I'm actually beginning to manage the beginnings of them, which is wonderful.* [Sarah, ER, 12/11/01]

*I think this place has a lot of at the moment, like this learning centre. This is helping me out. I have my own things I can be getting on with, I can get on this business management course. Things like that, helping people to get going again ... and make a bit of money and assistance for a length of time, so they don't have money worries, until they have enough confidence.* [Liam, SL, 10/9/01]

Viewing TAG in the wider context of the predominantly rural areas where it operates in the Highlands, we can surmise that opportunities for activity, be that work or leisure activities, are in short supply for those with mental health problems, due to physical location, socio-economic circumstances and mental health status of users. Hence, the value of the scheme is increased for rural residents.

Users also suggest that TAG is in some ways therapeutic through providing individuals with a routine and an alternative focus to their mental health:

*I like TAG, gets you out and puts you into a routine. You know, if you haven't been keeping [well], it helps your mind, you know what you are doing ... no it's good.* [Peter, ER, 12/11/01]

*I think it's a very good starting point because you're not focused on yourself at all, you're focused on doing something, and learning something.* [Sarah, ER, 12/11/01]

The aim of TAG is to provide a stepping stone into the world of work or further education, and to this end it has facilitated voluntary and part-time placements with employers. Greg explains his own situation whereby after a number of work

placements he secured employment, noting '*[t]hat's the difference, to have something to go on to*' [Greg, INV, 18/6/01]. However, given the wider economic context in which TAG operates in the Highlands, of high and seasonal unemployment and underemployment, coupled with the stigma attached to mental health problems and cultural misunderstandings about what this entails, employment opportunities for this group are low. This is not to suggest that TAG is not providing a worthwhile service, quite the contrary. Indeed, as we have shown through user accounts, to those who access the service, it provides not only the provision of training and skills in a supporting environment, but helps in a meaningful fashion to enhance user networks and to relieve the isolation which many experience in their lives.

### **User views on medication**

This brief section does not discuss the general view of people with mental health problems on medication use *per se*, but merely relates several points made about the significance of taking medication in rural and remote areas. One of the most important contexts for understanding medication use in such places is that there are often no alternatives for mental health care; in short, there are few opportunities, if any, for talking treatments, group work, attending day care and drop-in centres, which all could be used as substitutes for a reliance on medication. Several interviewees raise this issue:

*I think you're better having group talks instead of pumping yourself full of tablets.* [Lorraine, NWS, 5/7/01]

*If I had someone to pop into maybe for an hour a day or whatever to speak to about how I was feeling, and how the depression had taken over my life, I probably wouldn't have wanted all the tablets. But because there wasn't anything like that ... you could be doped up to the eyeballs and not have cared ... because you had no one to speak to.* [Stephanie, NWS, 17/7/01]

There is a suspicion amongst many in rural communities that the use of antidepressants is prevalent, but unspoken about: '*Half of Lochinver's on prozac – I'm telling you*' [Ruth, NWS, 5/7/01]. For people with serious mental illness in rural area, though, there is a sense in which their primary carers, their GPs, do not understand enough about their medication to administer it properly:

*From 1976-1989 in Tain, during that entire time, there wasn't a single doctor in either practice that actually knew anything about schizophrenia, and when I was coming off medication towards the end of my time there, I was deciding what medication would work best ...* [Roisin, ER, 21/11/01]

There are also suggestions from others that the lack of understanding of particular practitioners regarding particular mental health problems has led to the over-prescription of certain types of medications:

*This woman I had seen, she didn't accept OCD, or she didn't know what it was. She was simply treating me for depression and that lasted for two and a half years and what that simply did was dampen me down. They gave me lots of drugs. I was a bit like a zombie.* [Fred, NWS, 24/7/01]

For some users with CPN care, it is clear that their medication types and levels are dictated by CPN expertise, which then throws into stark relief the limited understanding of psychiatric medications possessed by a good few GPs:

*Whatever the CPN says, he will do, which is quite good, so I don't think he is very good at mental health problems, but he is quite willing to ... you know, the CPN can phone him from here and say 'can Deborah have such and such a tablet?' or 'can I dose her up?' ... and he'll send it out. So he relies heavily on her and she's quite good. [Deborah, NWS, 23/7/01]*

For those interviewees whose medication is monitored primarily by CPNs, there is the previously mentioned issue of the time lag between visits – partly a problem because of the large catchment areas involved – as linked to the altering of medication levels:

*So you had to wait for another visit from [the CPN] to come and discuss the side effects, and then go on to a different medication without having to go through the system ... and it takes so long for the medication to kick in ... . [Darren, NWS, 18/7/01]*

At the same time, these perceptions, and the rather limited contact with rural CPNs, can mean that some patients are tempted to withdraw from medication use without supervision, especially if they are unhappy with side effects and cannot contact the CPN to discuss matters:

*I came off them, I had a bad time coming off them, but I did it all by myself. The CPN had been on holiday and then I'd missed her, and then I must have been away when she called and it just went on and on and I thought 'och I think I'll try stopping these for a wee while. [Deborah, NWS, 23/7/01]*

People in rural and remote places may not have the chance to discuss the effects of medication with other users, especially if there is no drop-in, and the use of strong medication can be more daunting for those not tied into a mental health service users network. As Daryl [INV, 21/6/01] indicates below, contact with others makes a great difference to perceptions of medication and also aims about levels of usage:

*I felt knackered all the time. You didn't have the strength to fight the illness, so I landed up in bloody hospital all the time ... . Then I went to this 'Hearing Voices' conference in Dundee, since then I've been quite hyperactive! ... . It just inspired me, the fact that the guy who sets up the conference has seven voices and he was on no medication.*

It is of course more likely that people with mental health problems in Inverness, where service user networks are relatively dense and bound into contacts with other users elsewhere in the country, will be the ones able to find ideas and support for turning to therapies without medication; it is less likely that such opportunities will arise for individuals in more rural and remote parts.

There is a sense in which medication can compound the problems of mental health difficulties, especially when it came to patterns of behaviour that might be noticeable or visible to the remainder of the community:



*I didn't go out of the house much, the main reason was the drugs they were giving me, I was on such a high dose that the slightest effort was tiring.* [Gordon, INV, 14/5/01]

The problem of visibility is also an issue in relation to the collection of medication in some communities:

*There was one very bad thing that happened in Mallaig. The chemist, the shop assistants who handle the prescriptions in the shop, they discussed it ... they were talking in front of the other customers. [ibid.]*

For most people in remote places this is not an issue, because medication deliveries happen via the local shop in anonymous packages, but such a delivery system also means that a pharmacist is not always on hand to explain medication use or side effects (as might be the case in urban areas). For many people whose lives have been adversely affected by mental health problems, the use of medication is important in helping them to traverse public social spaces from which they may otherwise have withdrawn:

*I've always refused to believe I'm not well by not taking my medication sometimes. And then I realised, 'oh gosh, I need it'. I suddenly realised I couldn't go on a train trip now, and I couldn't go on a bus trip, and I suddenly realised how my world had shrank. [Sarah, ER, 12/11/01]*

In the sorts of areas with which we are dealing in this study, Sarah's realisation that she was now unable to use public transport really does signal a moment when, as she implies, the 'shrunk' character of her local world must have become painfully obvious.

Overall, psychiatric medication use in rural and remote areas raises a range of particular issues, including the prescription of powerful medications through non-expert GPs (who occasionally may not have the advice of a psychiatrist consultant); the delivery of medication through village shops and local surgeries; the visible effects of medication in small communities; the time lag in discussing the effects of medication with expert service providers; and the risks of coming off medication in unsupervised conditions.

### **User views on gaps and future provision of care**

People in all four case study areas raise issues about gaps in the current provision of care and the need for certain kinds of future provision. For some there is a distinctive geography to their claims for future services: *'I think there should be something on the west coast, more support on the west coast'* [Connor, NWS, 16/7/01]. More generally, for many people, especially those in rural and remote areas, there is a concern for a wider range of provision, with a clearly identified need for more psychologists and more CPNs than there are presently in the current provision:

*The psychologists up here, we don't have any really ... things that are taken-for-granted in Glasgow or Stirling. [Collete, SL, 19/9/01]*

*We want psychologists here and not in Inverness, it would make such a difference, it would almost be instantaneous. It's someone to talk to. At the end of the day it is isolation, that's the whole problem with mental health in*

*the Highlands, the feelings of isolation, stigma, ignorance you know and that is why forty-three people a year kill themselves in the Highlands.* [Phillip, SL, 9/8/01]

*I know the budget for Skye and Lochalsh here, but I think they could have one or two more psychiatric nurses to spread, so people can have a choice.* [Pauline, SL, 20/9/01]

*Within the island, we need at least another CPN.* [Cameron, SL, 25/9/01]

The latter point makes clear that, for many people who have CPN provision in remote areas, there is never really any choice of who is the service provider. Thus, if the skills and personalities of the one or two CPNs do not match a client's needs, then there is no second choice for rural residents. It is quite revealing that clients from Skye and other areas specifically ask for psychologists and CPNs, referring to these providers by their professional titles, hence indicating an informed awareness of available service provision. By contrast, people from North West Sutherland, one of the most under-served areas in the Highlands, use less professional language in order to ask for 'someone', 'an 'auntie-type figure' (see below), indicating a general lack of awareness about what could be available to them in the mental health field.

Specifically, it is identified that there is a need for some form of daily support for people in rural places, and a clear message that weekly or fortnightly meetings with a rushed CPN is not enough of a support system or constitutive of 'good' community care:

*I would see [the CPN] each week - but I could have done with someone some days, I could of - in between - I could have spoke[n] to somebody.* [Lorraine, NWS, 5/7/01]

*I'm sure I'm not just speaking for myself, but, you know, it's now to once a fortnight, and to me, because I can't speak to anyone else, once a fortnight is an awful long time, you know what I mean ... it's just not good enough.* [Stephanie, NWS, 17/7/01]

In particular, having access to CPNs outside of normal office working hours is deemed important for many people, but they also identify that this presents difficulties in large geographical catchment areas:

*You cannae get a CPN at a weekend ... there's no cover, which I think is wrong ... . To get someone across like [CPN] ... she lives on [another island] ... they would need to put on a ferry for her ... so on that side of the service, it's pathetic.* [Glenn, SL, 6/9/01]

Some interviewees make more detailed comments about the types of workers that should be providing such CPN services in remote Highland areas. Here interviewees demonstrate sensitivity to social differences between Highland residents and an identified need for more 'local' understandings in service provision, perhaps through the employment of 'local' service providers:

*It almost needs like a Frank [her partner] to go into these homes ... . He understands the lifestyle ... he is indigenous to this part of the world ... he*

*has lived and worked this part of the world and he would be more received.*  
[Maureen, NWS, 26/9/01]

This client therefore raises an issue about how some psychiatric workers may be rejected by local community members because they are perceived as themselves ‘alien’ to local cultures and norms in various ways. This could in part be related to matters of language use (Gaelic), but may also be related to more nuanced considerations such as fears relating to whether the provider understands the importance of confidentiality in the context of how local gossip networks operate on the basis of shared visible information (see our findings paper on **Visibility, gossip and intimate neighbourly knowledges**). Such matters may then affect service uptake amongst local members of the community, with incomers being less concerned about the relations between service providers and the workings of rural community.

Beyond CPNs, there is a stated need for more multi-faceted general support workers who could help with outreach work, tasks around the home, shopping and the building up of routines. These services are raised particularly by women with domestic responsibilities, notably those who face mental health problems while bringing up young children:

*I could have done with someone to come round and do something physical ... even just to make sure my kids were ok ... . Auntie-type figures would be fine.* [Jessica, NWS, 18/7/01]

Apart from the need for both a greater range of and some increase in the numbers of mental health workers in rural places, there is a call for the existence of so called ‘safe places’ in the community. People with mental health problems sometimes request access to respite care, in which they could make use of a space to recover from difficulties without the need for hospitalisation:

*I need a safe place to go with somebody who knows about mental health problems, not saying it should be a nurse or a doctor, just someone who knows and understands and can keep me safe until an psychotic episode passes. Similarly, I suffer from depression, and if I was depressed the last place I want to go when I’m depressed is a hospital. No good whatsoever.* [Maria, INV, 21/5/01]

*I think if there was a place that people could go to talk, it might stop a lot of people being admitted to hospital.* [Charmaine, ER, 22/11/01]

*Possibly having a psychiatric bed in the [local general] hospital so that when someone is in crisis, they have somewhere to go. At the moment, all we’ve got is New Craigs and that’s 150 miles away.* [Hazel, SL, 13/8/01]

The comments above begin to explore the possibilities for crisis care as well, a large concern for many interviewees, and one covered in another section of this paper below. Beyond the existence of ‘safe places’ for those in difficulties, there are also calls for more activities and occupational therapy sessions<sup>3</sup> – especially in North West Sutherland and remote parts of Skye and Easter Ross:

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<sup>3</sup> These are the sorts of activities that the TAG units can provide, and we certainly see a role for TAG in meeting the kinds of ‘service gaps’ being identified here. The TAG provision in North West

*Even it was arts or crafts or something ... . The thing is up here is there's not enough for people up here - I think that's why they end up in the Craig Dunain - there's just not enough. [Lorraine, NWS, 5/7/01]*

*But there is not much in place if you are suffering. People are just kept at home and left to your own devices a lot more I think, that's my experience anyway. There's not as much about getting you out into the community so much. [Leah, ER, 4/12/01]*

In addition to formal service provision with trained professionals, community groups that deal with mental health issues are cited as important in terms of their role in supporting rural residents and educating others:

*Because what is needed here is, like, a very revolutionary type of women's group ... where women start to talk about these issues and demand what they need. [Ruth, NWS, 11/7/01]*

*Like-minded people would make a difference, I suppose, stimulating people, or just people you could actually talk to, and there are very few of them out here, I can't think of a single soul. [Deborah, NWS, 23/7/01]*

In light of the risks associated with community knowledge of mental health problems – as discussed in our other findings papers about **Visibility, gossip and intimate neighbourly knowledges** and **Experiencing mental health problems in the Highlands** – some users identify the need for the formal organisation of innovative and discrete community groups in rural and remote Highland places:

*Because of the issue of visibility, there would be a bulletin system for people with mental health problems in the area, then they can be made aware that a facility is just for them. Then when they go down, nothing is advertised in the village, just advertised specifically to the people with problems ... . [Gary, ER, 12/12/01]*

For others, their suggestions for future provisions are tempered by knowledge of community attitudes:

*I've wondered whether some group could be set up ... self-help to a degree ... to take, I don't know, possibly even a bit of the strain off the CPN situation. But then, you're back to 'do people want to speak about it in a community this size?'. [Lisa, NWS, 11/7/01]*

This is hence more evidence that users in remote areas are thinking about how to reduce the care burden on CPNs in ways that protect the quality of this existing service, while also suggesting innovation and change. For those people who do live in the catchment area of a drop-in service or community group, there is a huge need identified for travel to allow them to reach the particular site of this provision:

*Getting transport to people to go places is important – that would be an issue – to go to the drop-in or HUG. [Gareth, NWS, 2/7/01]*

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Sutherland, as indicated, amounted to one trainer going out to assist individuals in their own homes, and it could possibly benefit from being more widely advertised.

*If I didn't have the car, I don't know what I would do.* [Sarah, ER, 12/11/01]

Or there is a stated need for more dispersed service provision:

*Maybe more outreach facilities in various parts, not only Portree.* [Eve, INV, 30/5/01]

For many of the interviewees, there is also a distinct need for an 'after hours' service of some kind, whether it be a telephone helpline or extended drop-in hours:

*A drop-in that is open out of hours, I think that was open at evenings and weekends ... that would be a help.* [Gareth, NWS, 2/7/01]

*A 24 hour service.* [Maria, INV 21/5/01]

*A telephone helpline probably would have helped. I think, maybe instead of going for a bottle of wine or whatever, I could have picked up the phone.* [Stephanie, NWS, 17/7/01]

*The Highlands is a very large area and a very diverse area, [and] it would be a good idea if we had more outreach projects and had more nurses coming out and maybe doing a clinic or something within the village, maybe run mental health awareness classes in the village, people can come along and see. Also [we] have talked about in HUG the possibility of a 24 hour call centre based within the Highlands and Islands area, dealing with the whole of the Highlands and Islands so that they could have a one stop service.* [Gary, ER, 12/12/01]

This wish list represented by some of our interviewees above points to just some of the suggested gaps in the current provision, and highlights a range of future options for service providers and policy makers.

### **User views on crisis services and after hours care**

This brief section highlights the strong feelings from interviewees over all four case study areas, but particularly those in rural and remote places, about crisis services and after hours care. Although these are two different service provision issues, users often discuss them together and they are evidently linked in the minds of rural residents. For those people who require help, assistance or advice after office hours or at weekends, there is little provision in the rural Highlands. For those in severe difficulties, hospitalisation is occasionally necessary as a result, often with GP and police intervention. Transportation to hospital via police or the rural ambulance service has sometimes been possible for people in such situations, although at other times, a police cell has had to be used as a 'place of safety' while transportation from Inverness hospital services is arranged. For some interviewees, this was a real source of anxiety, and they express clear views about the need for further resourcing in this area:

*Have a service here, either in Portree or Portree hospital, where they've got a couple of beds that can be utilised for mental health patients ... so, rather than take them all the ways to Inverness, to bring them all the way back through the next day, they could set it up here.* [Glenn, SL, 6/9/01]

The process of crisis intervention can be frightening, stigmatising and, as the following extract shows, physically and psychologically disturbing:

*They came and charged in the door and injected me ... straight in the back of the ambulance ... knocked me out for two days. I was walking round like a zombie. They gave me too much of that stuff.* [Jason, NWS, 19/07/01]

For those people who had experienced such dramatic intervention, there is a sense in which the procedure itself could be subject to more sensitivity:

*Why be handcuffed? And I was taken to [a] 10 by 4 police cell, and I was locked up and treated like an animal. The local ambulance refused to take me and left me in the police station, and they had to get the heavy mob up from the Craig and that's 100 miles away and of course. The police don't know how to handle me. It's pretty drastic measure they use nowadays to restrain people ...* [Jason, NWS, 19/7/01]

Although such dramatic events are rarer in the Highland than in urban areas, this does not obviate the need for the development of crisis services in rural and remote places. As such, many interviewees suggested services that might help to prevent such crises:

*If you had someone there, that if you were worried, you could phone up and you could prevent the crisis, [that] is sometimes enough.* [Miriam, ER, 13/11/01]

In Inverness, there is actually an out-of-hours telephone CPN service, and this has undoubtedly proved beneficial to some during crisis situations:

*At the moment I can speak to a CPN until 11.30 at night, but if that was on 24/7 just to discuss things and get feedback that would be helpful. Every time I have used the CPN service on the phone ... I mean that can't cost very much ... and every time I have done that I've gone on to, the situation, gone on to require no further intervention.* [Danny, INV, 14/5/01]

Yet, in more remote areas, at night and weekends and when CPNs are away, there is often no other back up should people go onto crisis:

*They come every fortnight like and there's a lot of vacant ground between 'em ... they could come today and I'm alright ... but then my mania goes up and I could be away with the fairies and there's nobody here. The last time I was, it was stress I was under, she was on a fortnight's holiday and you couldnae get in touch with her so there was nobody.* [Jason, NWS, 19/7/01]

The provision of an after-hours advisory service was hence considered important by rural users and linked to their thinking about crisis care. Many were convinced that crisis transportation to hospital could be avoided if there was more *in situ* service provision in times of crisis.

## Appendix One: Specific area-based services

### Easter Ross: the Travelling Day Hospital (TDH)

Within Easter Ross, the Travelling Day Hospital (TDH) is an important site in the mental health services landscape, contributing to the sense of a mental health community. In this brief section, the role and importance of the TDH will be discussed from user perspectives. Before this, we provide some brief background on the TDH by way of contextualising the users' views.

The TDH is unique in the Highlands, and it was established in 1989 with a remit of providing day care services for people with mental health problems living in rural communities in Easter Ross. During the project three people – one charge nurse, one staff nurse and an occupational therapist – formed the TDH team. Referral is formalised, with GPs, consultant psychiatrists or the area mental health team being the main routes into using the TDH. The team base and time is divided between Invergordon and Muir of Ord, the latter representing the divide between the Easter Ross area and the Inverness areas. From these bases, the TDH travels to towns and villages throughout the Ross area: Alness, Tain and Dingwall, the main centres of population for this mixed rural/urban area. With its specific remit of providing services for those in rural communities, the TDH covers a wide area. The staff are responsible for one hundred cases at any one time, the majority of whom they will see at the TDH, with home visits to individuals being co-ordinated with respect to the location of the TDH on any particular day. In order to fulfil group and individual work, the TDH finishes group work around 3-3.30pm. The TDH uses a variety of sites for its group work. The majority of its sites are multi-purpose providing a necessary 'cover' to ensure the comfort of users (see our findings paper on **Visibility, gossip and intimate neighbourly knowledges**), and they include: an old people's home, a youth café and a community centre. In contrast, Companas Cottage, a drop-in located in Alness, is used as an explicit mental health site within the community. In both Tain and Dingwall, two TDH groups are held. These are differentiated by age and location. Given that many who use the service live in rural locations, transport is a concern, with users using taxis (which are paid for by the TDH) to go to and from the various TDH sites.

The TDH day has a defined structure to it, although this is not rigid and varies depending on the group in question. Activities take place throughout the day and individuals are administered medication and given one-to-one support with a staff member as and when required. Aside from the main group, the TDH also run specific clinics for those with mild and moderate mental health problems, dealing with stress and anxiety management. The fact that the TDH is a mobile psychiatric service circulating around remote and rural landscapes means that users of this service have to deal with the visibility issues surrounding their access to it:

*Even when I go to the Travelling Day Hospital in Dingwall, I used to park the car in the complex, the community centre the TDH use and there is also a library, and a Gaelic school for kids. The neighbour across the road said to [his] wife 'I quite often see Simon's car there on a Friday', and again the wife – I think she knows I get embarrassed, I haven't actually told the neighbours what my problem is – she just said 'oh he goes to the library regularly'. She tries to cover up for me. [Simon, ER, 19/12/01]*

For this user, the location of the TDH in a multi-function site acts as a useful cover for if neighbours should notice his car while he is attending this psychiatric service. That the TDH also uses a van to pick up clients from particular locations also involves a 'risk' for clients who are concealing mental health problems. However, the fact that the TDH operates from several sites in the area, rather than just the one, enables rural residents with concerns about 'invisible' service use to utilise a site further away from their places of residence, thus lowering the risks associated with access.

Users who do use the TDH interpret the service as providing a number of crucial functions, including help with routine, formal and informal support (see also our findings paper **User networks**), and also the constitution of a place of safety and activity. One of the main aims of the TDH is to combat the social and physical isolation which users experience as a result of their mental health problems and place of residence. In our findings paper on **Remoteness, rurality and mental health problems**, users provide eloquent accounts of the ways in which they feel socially and physically isolated. TDH users spoke of the role of the TDH in combating such isolation:

*Again it is a means of getting people out and meeting with their peers kind of thing. That's what I get out of it. [Simon, ER, 19/11/01]*

*But I also think these things are important because people don't get too isolated, you know, at least if you've got this, even if it's only just once a week, they've got that contact with other people, you know. It gets them out and meeting other folk and socialising a wee bit. [Charmaine, ER, 22/11/01]*

Users value the place of the TDH in their lives, recognising that it makes up a significant part of their day to day existence, providing an element of routine which would otherwise be lacking for many:

*I think that I have got these things to come to has been a good thing because if not I know myself it is so easy to fall into a rut, get up in the morning having a wash and something to eat and parking myself down. The wife watches the morning TV things and so, easy, before you know it, it's noon. Having sat there half the day you just want to do that the rest of the day, I found that a terrible existence. So coming along here and the TDH, it's almost half my week, which I think is really helpful. [Simon, ER, 19/11/01]*

*Monday I got to Alness and the TDH .... I do nothing but make tea, smoke fags in the morning. About 1.30 go to the leisure centre to play indoor hockey, badminton or football. I just go home and do whatever for the rest of the day, do anything. Tuesday I go to Tain, TDH for the music there. Wednesday I do my housework and do a wee bit of cooking for two days. Thursday I come here [TDH], as you know. After this probably just go home and watch TV, go down to friends. Friday I've a friend will take me out to go stuff, do stuff I enjoy doing. This Friday we are going to the pictures, see American Pie 2. [Keith, ER, 15/11/01].*

The TDH also provides a place where users feel accepted: 'It's [TDH] very important. Just knowing everybody in there has trouble and that, it's just like being at work' [Anthony, ER, 21/11/01]; 'I just come to feel normal again. Some people come to this



*place have got problems, so this is why I feel normal, everybody has got problems same as me, so I feel normal, don't feel the odd one out'* [Keith, ER, 15/11/01]. Anthony's and Keith's comments suggest that within the wider community they do not feel 'normal'. Given interviewees' comments about often feeling out of place in the wider community (see our findings paper on **Exclusionary social relations**), the TDH can provide a safe place to be ill, where users can act out their emotional distress without fear of recrimination.

Anthony's phrase '*it is just like work*' suggests a sense of comradeship with other users, and the idea of fostering user networks across services is developed further in our findings paper on **User Networks**. It is perhaps worth drawing on some specific user comments around the support offered and taken up by other users of services. Talking is an important foundation for the development of user networks. While users are encouraged to talk in a more formalised setting of therapeutic group work, talk between users also takes place informally. Interviewees hence speak of the underlying support and connections made between users of the TDH:

*I'd be happy to come here, even if I didn't feel well because I know when I got here, that everybody here would be here for me sort of thing, you know, 'cos we're quite a close group the lot of us.* [Charmaine, ER, 22/11/01]

For Simon, the opportunity to connect with others '*in the same boat*' is the main benefit of attending the TDH rather than the activities that take place:

*I don't think it is so much the content as you can see one or two people you always are comfortable with because they understand that you are in the same boat as you are, you know? I think that is a great thing.* [Simon, ER, 19/11/01]

Despite Simon's opinion that the therapeutic activities (the 'content') taking place are relatively unimportant, many users disagreed. Sharing experiences within a group facilitated by a staff member in some ways formalises the support provided by other users:

Jack: *Although you are in a group session here, which can be quite useful.*

Interviewer: *What sorts of thing do you talk about?*

Jack: *Talk about things bothering you, talk about if anything comes up. Self esteem.* [Jack, ER, 16/11/01]

*The staff and the fellow students, or how should I put it, clients, there is a group of us go out in the afternoon to feed the ducks and go for a walk. We discuss any problems that anybody has had in the previous week. I think we do each other good.* [Guy, ER, 13/12/01]

Other, more leisurely activities within the community also take place, and these are intended to foster relations between individuals and their wider community, improve social skills and build up the confidence of users. Users enjoy these activities, with many not having the opportunity to access these activities due to financial and transport constraints, aside from the limitations of their mental health problems, as Charmaine relates: '*But the Travelling Day Hospital, they're very, very good. Plus they take us out to places too, you know. We go to the movies or roller bowl for a lot of us, it's the only time we would get to places like that, you know*' [Charmaine, ER,

22/11/01]; *'I look forward to the Travelling Day. We go to the movies on a Tuesday sometimes. I look forward to things like that'* [Anthony, ER, 22/11/01].

While activities, informal support and socialising with other users are all important to users of the TDH, the availability of professionals is still an important factor in the success of the service. The ability to have professionals on hand at least once a week, while perhaps not necessary for all users all of the time, acts as a safety net for people:

*Companionship, again people that I can discuss medical things with if I need to.* [Guy, ER, 13/12/01]

*Someone is willing to listen to you. You put all your thoughts into perspective more, you can tend to let things build and build up and unless you can share it, it's usually childhood memories and things happened in the past. You can't keep things bottled up and sometimes you realise, well that's not true. Things that you thought aren't true and you try and work the things out. That way it's a positive thing.* [Gerry, ER, 19/11/01]

*Least I know there is two places [TDH and supported accommodation] I can seek help if I really needed it.* [Keith, ER, 15/11/01]

Placing such remarks within a wider context of service provision throughout the Highlands, this ability to talk to someone as and when required is often mentioned by users as a possible gap in service provision for a number of the areas. Clearly, users' comments on the TDH suggest that it is providing a worthwhile and invaluable service for those whom it is seeking to support. By doing so it is achieving a number of its aims around combating isolation, developing social skills and building links with the wider rural community.